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NEWSLETTER

Indiana State Department of Health

Epidemiology Resource Center
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Indiana's Melting Pot: Changes in Indiana's Population

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Indiana's population has increased by 9.7% from 1990 to 2000. Diversity is also on the rise all over the state. Out of 6,080,485 Hoosiers, 13.3% are racial/ethnic minorities. Before exploring Indiana's new growth, it is important to be aware of the new racial and ethnic definitions provided by the federal Office of Management & Budget. The minimum categories for data on race and ethnicity for Federal statistics, program administrative reporting, and civil rights compliance reporting are defined as follows:

- **American Indian or Alaska Native -** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- **Asian -** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **Black or African American -** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
- **Hispanic or Latino -** A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."
- **Native Hawaiian or Other Pacific Islander -** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- **White -** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

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There is increased concern within the state and the nation regarding health disparities, in particular minority health disparities. One crucial goal of Healthy People 2010 is to eliminate health disparities. In order to reach this great aim, it is important to examine the changes in Indiana's population. Indiana's health services must meet specific challenges of a growing and diverse population's health needs and concerns.

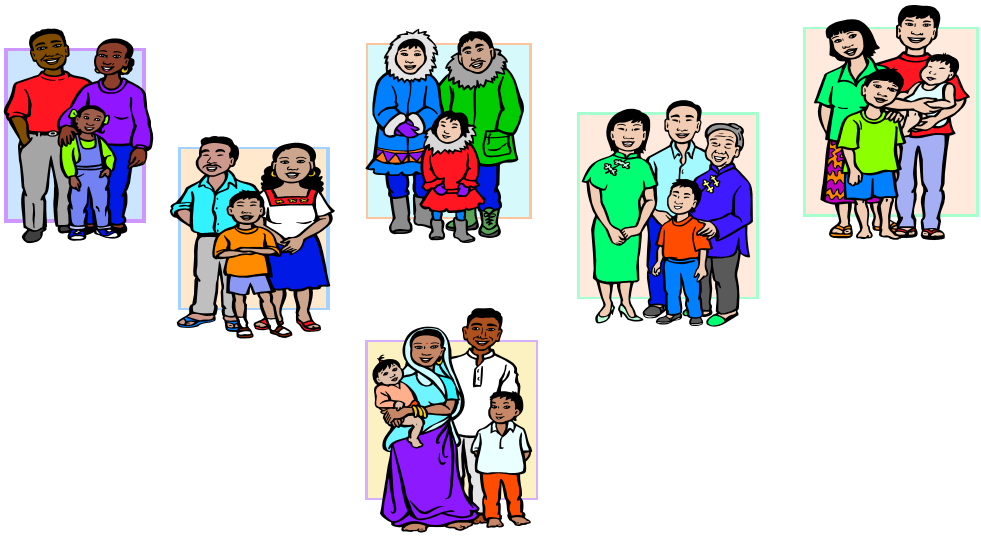
Indiana Populations

RACE/ ETHNICITY	*1990*	*% of Change*	*2000*	*Race alone or in combination with 1 or more other races*
American Indian/ Alaskan Native	12,720	24%	15,815	39,263
Asian Americans/ Pacific Islanders	37,617	63%	61,131	77,206
Black/ African Americans	432,092	18%	510,034	538,015
Hispanics/ Latinos	98,788	117%	214,536	N/A
White	5,020,700	6%	5,320,022	5,387,174
Indiana Total:	5,544,159		6,080,485	

The Office of Management and Budget has developed regulations for government programs and all those organizations or institutions that are financially supported by the government. These regulations state that when collecting data on race or ethnicity, individuals have the right to racially or ethnically identify themselves. All previously mentioned government entities must comply. Self-identification played an important part in the 2000 Census. This was the first census were an individual could choose more than one race or ethnicity. In total there were over 63 different race and ethnic combinations.

The ISDH Epidemiology Resource Center Surveillance Investigation Unit is currently compiling a report on minority health disparities within Indiana and comparing Indiana data with national data. The report will display the top 10 leading causes of death for each race and provide other data and statistics beneficial for minority health disparities research. If you would like more information please call or email Antoniette Holt at 317-233-7627 or aholt@isdh.state.in.us,.

Note: The data used in this article were provided by the U.S Census Bureau.



Correction in August Epidemiology Newsletter:

In the article *Influenza Vaccine for the 2001-2000 Season*, one of the ACIP High Risk Target Groups was inadvertently omitted. **The list also includes adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including asthma.**

We regret the error, and thank the reader who brought this oversight to our attention.

The *Indiana Epidemiology Newsletter* welcomes hearing from our readers. Please e-mail your comments to ppontones@isdh.state.in.us.

Impact of Eating Disorders in Indiana

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ISDH Community Nutrition Program

Introduction

In the United States and in Indiana, there is an abundance of food -- some healthful and some not so healthful. Consequently, obesity is a major public health problem. In this setting it is difficult to understand that some people are starving to death. To make matters worse, they are doing this intentionally. Accurate data on prevalence of eating disorders are unavailable due to under reporting, but it is estimated that more than five million Americans suffer from eating disorders. That means that approximately 5% of adolescent and adult women and 1% of men have eating disorders.

Definitions

Most eating disorders fall into three categories: 1) anorexia nervosa; 2) bulimia nervosa; and 3) binge eating disorder. Most other eating disorders are lumped into a category called Eating Disorders Not Otherwise Specified (EDNOS). Eating disorders result in tragic medical and emotional consequences. Young women with eating disorders have a death rate 12 times higher than for other women of similar ages. An estimated 1,200 women die each year from anorexia nervosa, the highest death rate recorded for psychiatric disorders. These numbers are almost impossible to substantiate since cause of death is usually listed as malnutrition, sudden heart attack and suicide.

Anorexia nervosa is usually identified by extreme weight loss -- at least 15% below their ideal weight. People with anorexia nervosa have body image disturbance and an intense fear of becoming fat. They are obsessed with food, weight and thinness. They will deny hunger and refuse to eat. Many excuses for not eating with the family are often given, including, "I already ate" or "I am just not hungry" or "I am meeting people and will wait to eat with them." They almost always deny they have a problem when confronted and perceive themselves as fat even when dangerously thin. Without effective treatment, 50% of people with anorexia nervosa will develop the symptoms of bulimia within two years of the onset of anorexia.

Bulimia nervosa is marked by secretive binge eating episodes followed by purging via self-induced vomiting, fasting, excessive exercising or use of laxatives or diuretics. Persons suffering from bulimia can be any weight from underweight to obese, but the majority are within the normal weight range. They deny the fact that the purging behaviors are ineffective in disposing of excess calories. With binge eating disorder, there are recurrent episodes of binge eating, but without the purging behaviors seen in bulimia. Although only 2% of the general population meet the criteria for binge eating disorder, nearly 8% of obese women and 30% of those seeking treatment from weight loss programs meet the criteria. Binge eating disorder is seen more in men and African-Americans than either anorexia or bulimia nervosa. It is estimated that as many as 25% of binge eaters may be male.

Causes/Historical Development

The earliest reported case of anorexia nervosa occurred in 1689 and by 1873, both anorexia and bulimia nervosa had been recognized and described as component symptoms of a pathological eating disorder syndrome. Their descriptions were very much like the ones used today. Sociocultural factors such as Western society's thin ideal and emphasis on weight loss are not the actual cause of eating disorders, but they definitely exacerbate the condition in people who are vulnerable to their development. Many therapists state that every eating disorder started with a diet. Usually, at first, the weight loss is intentional and positive feedback from others can reinforce the weight loss. Those who develop an eating disorder will become increasingly obsessed with body shape and weight and unable to eat normally, beginning the downward spiral to an eating disorder.

Outwardly, the primary focus is on weight and food, making it difficult to make the connection to feelings, thoughts and stress factors. Basically, an eating disorder is not about food, but a complex illness, which results from various combinations of psychological, social and biological issues. A person who is prone to development of an eating disorder has feelings of low self-esteem; has difficulty with change and a preference for things to be predictable, orderly, and familiar; and is usually a perfectionist with very high achievement expectations.

Diagnosis and Treatment

The most difficult part of diagnosis and treatment is for the person to admit to having a problem and be willing to seek treatment. With early identification and treatment, 70-80% of people with eating disorders respond well. Denial is a major factor, especially for a person with anorexia nervosa. Secretiveness and the obsession with maintaining control over their bodies lead to false reassurance they give when confronted about the situation, and often leaves family and friends confused. This type of behavior can delay treatment until the condition reaches a point where treatment is difficult or ineffective. Almost every major organ is affected by anorexia nervosa. Loss of the menstrual cycle is more than a temporary symptom. It leads to a much higher rate of infertility, miscarriage and premature births. Osteoporosis can develop and result in seven times the normal rate of fractures among women in their 20's who have chronic anorexia nervosa. This condition may not be reversible even with estrogen supplementation and weight restoration.

Eating disorders are multi-faceted psychological conditions with medical and nutritional overlays. Therefore, treatment must involve a multidisciplinary team. The choice and duration of a treatment option is critical. It is important to choose a team that specializes in eating disorders and to continue treatment until the patient is fully recovered. Persons with anorexia nervosa should restore their weight at approximately 2-3 pounds per week. As a general rule, the slower the weight is restored, the longer the weight restoration is sustained. If these patients are discharged before restoring weight to at least 90% of expected body weight, the likelihood of relapse doubles. Many people expect a drug intervention to achieve instant success, but most of the psychotropic medications are not effective until the patient reaches the 90% threshold. A list of eating disorders treatment providers in Indiana, compiled by the Eating Disorders Task Force of Indiana, can be found at www.in.gov/isdh/programs/nutrition/eating_disorders_providers.htm.

Barriers to Treatment

Denial and resistance to treatment are major barriers. Not only the person with the eating disorder, but the parents and other adults in this person's life are likely to put up these walls. The parent may fear being labeled as a "bad" parent; the coach or dance instructor may fear being accused of creating or contributing to the problem; other adults may avoid the issue because it seems overwhelming, too complicated, or because they fear interfering with training or success. An athlete must understand she/he will never reach full potential with an eating disorder. Weight may be important for certain athletes such as gymnasts, swimmers, wrestlers and dancers, but it is not the only performance factor.

Insurance coverage can be a barrier. Eating disorders were once thought of as diseases affecting only wealthy girls. This may have occurred because they were the only ones who could afford treatment and were, therefore, documented. Health insurance policies vary greatly in coverage of psychiatric conditions. Many variables exist, making prediction of exact length of treatment impossible. Managed care plans and HMOs often resist coverage of treatment for eating disorders for a variety of reasons.

Challenging the health care system or the employer who purchases the plan requires a degree of assertiveness seldom found in an eating disordered patient. Unless the person with the eating disorder has someone to wage this battle for him/her, recommended treatment may be denied or delayed until the condition worsens. Delaying treatment is not a cost-saving matter in the long run. Teenagers and some college students may be covered on their parents' health insurance. The insurance company who manages the health care funds and the employer who sets down the rules for the insurance company may not understand the urgency of starting a treatment program. Sometimes, they may intentionally delay until the person is no longer part of their program and, therefore, no longer their problem.

Most large colleges and universities have psychological services as part of their student health services. A large portion of these psychological services is often used for treating eating disorders. It is essential to explore all options for treatment in a timely manner to prevent life-threatening delays.

Prevention of Eating Disorders

Primary prevention of eating disorders involves addressing the real causes. Young people need more than knowledge of healthy nutrition principles. They also need help with realistic body ideals, self-esteem, self-efficacy, interpersonal relations and coping skills. They are faced daily with societal pressure to conform to unrealistic body ideals and to achieve unrealistic goals. They must have support to deal with those pressures.

Secondary prevention involves early identification of warning signs and referral to appropriate treatment. Every person who is in contact with young people share in this responsibility. Tertiary prevention involves providing a supportive environment to prevent relapse in a person who has been successfully treated for an eating disorder. Obviously, primary prevention is the best choice for all involved.

Conclusion

Eating disorders are serious, multifaceted conditions which will not go away by themselves and must be faced. Untreated, they not only limit the individual's potential, they are life-threatening! It is imperative that eating disorders be identified and treated early in their development. The person with the eating disorder, parents, teachers, coaches, friends, and others in his/her life share in the responsibility help the person recover.

Resources

The following organizations provide further information on eating disorders:

Anorexia Nervosa and Related Eating Disorders (ANRED)
P.O. Box 5102
Eugene OR 97405
Phone (541) 334-1144
http://wwwanred.com

International Association of Eating Disorders Professionals (IAEDP)
123 NW 13th Street, #206
Boca Raton, FL 33432-1618
Phone: (800) 800-8126

Ghrze Books
P.O. Box 2238
Carlsbad, CA 92018
http://www.gurze.com

Indiana State Department of Health
Community Nutrition Program
2 North Meridian Street, 6B
Indianapolis, IN 46204-3006
(317) 233-7793
http://www.state.in.us/isdh/programs/nutrition/nutrition_e-dis.html

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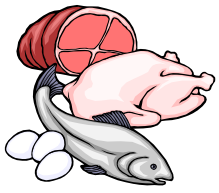
Cholesterol: Essential to Life, Yet a Major Public Health Problem

September is National Cholesterol Education Month

Elizabeth L. Hamilton-Byrd, MD
ISDH Epidemiology Resource Center

What is cholesterol?

Cholesterol is a soft waxy **lipid** (fat or fat-like substance) found normally in the blood stream and all cells of the human body. The healthy human liver produces cholesterol from small molecules (carbohydrates, proteins, and fats) derived from the digestion of common foods. Nonhuman animals, but not plants, also produce cholesterol; therefore, we consume cholesterol solely in foods of animal origin – meats, dairy products, and eggs.



What is the importance of cholesterol in our bodies?

Cholesterol is a component of the membrane of every cell in our bodies. The myelin sheath, which surrounds individual nerve fibers permitting the rapid transmission of messages along the nerves, is composed of approximately 23% cholesterol. Cholesterol is the building block from which all of the steroid hormones in our bodies are made. These hormones include: cortisol, which is necessary for the storage and use of the food energy we consume; aldosterone, which is important in the normal function of our kidneys; and the sex steroids – estrogen, progesterone, and testosterone. Vitamin D and bile salts, which help to digest fat, are also made from cholesterol.

Why is cholesterol a problem?

Only a small amount of the cholesterol in the blood is needed for all of the important uses of cholesterol in the body. When there is excess cholesterol circulating in the blood, cholesterol is deposited in the arteries, including the arteries of the heart and brain. These deposits cause narrowing of the lumen or pathway through which blood flows and can lead to an insufficiency or blockage of the blood supply to the heart or brain, resulting in a heart attack or stroke. **Atherosclerosis**, the disease process in which cholesterol and associated substances are deposited within the walls of arteries, also affects other parts of the body. When atherosclerosis causes an insufficient blood supply to the legs, people may suffer crippling pain on walking, a condition known as intermittent claudication. If the blood supply to the leg is blocked, gangrene and the need for amputation may occur. When atherosclerosis causes blockage of the blood supply to the kidney, either directly by deposits of cholesterol in the renal artery or indirectly by cholesterol emboli (pieces of the cholesterol deposit or plaque that break off and are carried to smaller arteries), kidney failure will occur.

What are "good cholesterol" and "bad cholesterol"?

Cholesterol and other lipids are transported by lipoproteins, organized groups or complexes of lipids and special proteins known as apoproteins or apolipoproteins. The lipoproteins are classified in order of increasing density: chylomicrons, very low density lipoproteins (VLDL), low density lipoproteins (LDL), and high density lipoproteins (HDL). All are necessary for the normal function of our bodies. They are produced by the liver and intestines. LDL is the major carrier of cholesterol from the liver to the parts of the body where cholesterol will be used. It is excess LDL cholesterol that forms deposits in the artery walls. For this reason, **LDL is sometimes called "bad cholesterol"**. HDL returns cholesterol from cell membranes in other parts of the body to the liver, facilitating the elimination of excess cholesterol from the body. Therefore, **HDL is referred to as "good cholesterol"**.

Who should have their cholesterol levels checked?

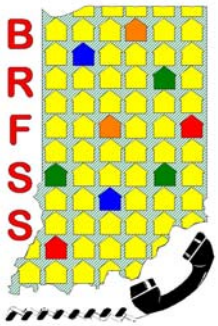
All adults age 20 or older should have their cholesterol levels checked by a fasting lipoprotein profile (total cholesterol, LDL cholesterol, HDL cholesterol, and triglycerides – the form in which most fat exists in foods and the body). Fasting levels should be repeated every 5 years or more often if the initial levels are abnormal or if you have other risk factors for heart disease. Routine screening of all children and adolescents is **not** recommended. Children who have a parent or grandparent with documented coronary artery disease (for example, a heart attack) at ≤55 years of age or high cholesterol (240 mg/dl or higher) should be selectively screened.

What do the different levels mean?

Cholesterol levels for adults have been classified by the Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (ATP III) as follows:

LDL cholesterol	
<100	Optimal
100 – 129	Near optimal
130 – 159	Borderline high
160 – 189	High
≥ 190	Very high
Total cholesterol	
< 200	Desirable
200 – 239	Borderline high
≥ 240	High
HDL cholesterol	
< 40	Low
≥ 60	High

How common is high cholesterol?



The Behavioral Risk Factor Surveillance System (BRFSS) 1999 Indiana Statewide Survey found that 31.5% of Indiana residents ≥ 18 years of age had ever been told by a health professional that their blood cholesterol was high. Indiana's percentage is slightly higher than the 30% found nationwide. The percentage of adults diagnosed with high cholesterol increases with age from 14.5% of those age 18 – 24 to 47.8% in those ≥65 years old. Women are slightly more likely than men to have been diagnosed with high cholesterol (32.4% of adult women vs. 30.4% of men). Non-Hispanic whites are more likely to have high cholesterol (32.5%) than African Americans (24.9%). The majority of Indiana adults (72.6%) have had their cholesterol checked in their lifetime and 65.2% of those had had it checked within less than a year.

KNOW YOUR CHOLESTEROL NUMBERS – KNOW YOUR RISK

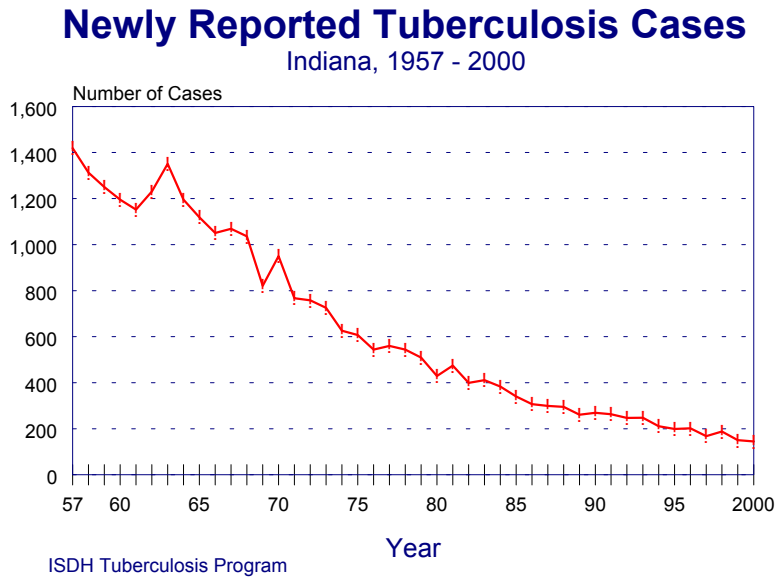
Latent TB Infection: What Is It and Why Do We Screen For It?

Paul Britton, R.N., M.S.
ISDH TB Control Program

When the word "tuberculosis" is mentioned, people immediately think of active TB disease and the images of very ill people with a chronic, persistent cough who spread this terrible disease to others. But mention "latent TB infection" to the general public and the chances are that no one will know what you are talking about.

Tuberculosis control has come a long way in Indiana, from 1,419 reported cases in 1957 to just 145 in 2000 (Figure 1). This decline is the direct result of effective chemotherapy for patients with active disease. But there is still a substantial amount of latent TB infection, which will become active in approximately 10 percent of those infected if they are not treated.

Figure 1.



What is latent TB infection? Tuberculosis is a progressive disease that destroys the tissues of the affected organ system, usually the lung in about 85 percent of all cases. People with TB typically complain of a chronic, persistent, productive cough, night sweats, fatigue, and weight loss. The infection is spread from person to person through the air by droplet nuclei containing the tubercle bacillus, *Mycobacterium tuberculosis*. Droplet nuclei are produced when a person with pulmonary or laryngeal tuberculosis coughs, sneezes, or engages in some other forceful expiratory activity. Only droplets that range in size from 1 to 5 μm are capable of entering the airways and establishing an infection. Droplets this small can also remain airborne for long periods of time due to air currents present in any indoor space. While larger droplets containing *M. tuberculosis* complex are also expelled, they do not serve as effective vehicles for transmission because they are generally too heavy to remain airborne. Even if inhaled, they do not reach the alveoli of the lungs.

Latent TB infection (LTBI), on the other hand, is the condition in which a person is infected with *M. tuberculosis*, has a positive TB skin test, but has no TB symptoms. He or she will usually have a chest x-ray that is free of any evidence of disease processes that would be suggestive of TB disease. People with LTBI are not contagious and cannot transmit TB to anyone. Only about 10 percent of people with LTBI will ever develop active TB disease at some point in their lives, with the greatest period of risk being within the first two years following infection.

The purpose of tuberculosis screening programs is threefold: (1) to identify persons with latent TB infection who are at high risk for progressing to active disease and would benefit from treatment, (2) to provide screening and treatment for persons who have the potential for occupational exposure to TB, and (3) finding persons with clinically active TB disease who need to be treated.

Who should be screened for TB? The following groups should be screened with the tuberculin skin test:

- ✓ Close contacts of persons known or suspected to have TB, i.e. those sharing the same household or other enclosed environments
- ✓ Persons infected with HIV
- ✓ Persons who have certain clinical conditions known to increase the risk for disease if infection occurs
- ✓ Persons with a history of inadequately treated TB
- ✓ Persons who inject illicit drugs
- ✓ Residents and employees of high-risk congregate settings (i.e. nursing homes, correctional facilities, mental institutions, other long-term care facilities, and homeless shelters)
- ✓ Health-care workers who serve high-risk clients
- ✓ Foreign-born persons, including children, who have recently arrived (within the last five years) from areas where TB is common. BCG vaccination is not a contraindication for skin testing.
- ✓ Some medically underserved, low-income populations, including high-risk racial and ethnic groups
- ✓ Infants, children, and adolescents exposed to adults in high-risk categories
- ✓ Locally defined high prevalence groups (substance abusers, migrant workers, the homeless)

Who should not be routinely screened with the tuberculin skin test? The following are examples of groups who do not need to be screened **routinely** for TB unless one or more of the above risk factors are present:

- ✓ School children and day care attendees
- ✓ Foreign-born persons living in the U.S. for more than 5 years who have been screened previously
- ✓ Pregnant women
- ✓ Food handlers

Who should receive treatment for LTBI? Treatment should be considered for anyone, regardless of age, with a positive skin test, who has not previously received treatment, and who falls into one or more of the following high-risk categories:

- ✓ close contacts of a person with infectious TB
- ✓ persons with HIV infection
- ✓ organ transplant patients, or patients with other immunosuppressive disorders
- ✓ persons whose chest x-ray shows stable fibrotic lesions consistent with old, healed and inadequately treated TB
- ✓ injection drug users
- ✓ persons with clinical conditions that make them high-risk, e.g. diabetes mellitus, certain forms of cancer, silicosis, end-stage renal disease, substance abusers
- ✓ recent tuberculin skin test converters (≥ 10mm increase within the past two years)
- ✓ recent arrivals from high-prevalence countries
- ✓ mycobacteriology laboratory personnel
- ✓ residents and employees of high-risk congregate settings
- ✓ children younger than 4 years of age
- ✓ children and adolescents exposed to adults in high-risk groups

In addition, close contacts to a person with active pulmonary TB who are HIV-positive, children younger than 4 years of age, and those with high-risk medical conditions, should be treated regardless of the skin test result. If a second skin test placed 10 weeks after contact is broken is negative, treatment can usually be stopped.

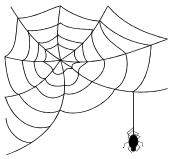
The recommended treatment regimen for LTBI is isoniazid for 9 months, regardless of age or HIV status. Isoniazid may be given to HIV-negative adults for 6 months if treatment for 9 months is not possible. Pyrazinamide and rifampin for 2 or 3 months for adults, or rifampin for 4 months for adults or children are alternate regimens that may be prescribed in certain circumstances, such as exposure to an isoniazid-resistant case. Dosages for all regimens are the same as for active disease. The alternate short-course regimens are strictly second-line recommendations and should not be used routinely in place of the isoniazid-based regimens.

Tuberculosis screening programs should be limited to individuals and groups who are at risk for exposure because targeted screening allows resources to be directed towards high-risk groups and away from those who are much less likely to be infected. All mycobacteria are genetically similar, so that those that are commonly found in soil and water can frequently cause a "positive" skin test. For this reason, the tuberculin skin test is a better test when its use is restricted to high-risk individuals. There are fewer false positives, which means less time and money are spent on unnecessary diagnostic evaluation and treatment.

Periodically, we in the TB Control Program get inquiries as to why school children and food handlers do not need to be routinely screened. School-based screening of school children and school employees was started in the 1950's when the disease rates were about ten times higher than what they are now. These programs now involve screening of large numbers of low-risk people. Food service workers do not need to be routinely screened because tuberculosis is not a food-borne illness. Generalized screening of such groups is not a cost-effective method of TB case finding or disease prevention, and should be discouraged.

References:

1. Centers for Disease Control and Prevention. *Core Curriculum on Tuberculosis, 4th Edition, 2000.*
2. American Thoracic Society and Centers for Disease Control and Prevention. "Diagnostic Standards and Classification of Tuberculosis in Adults and Children." *American Journal of Respiratory and Critical Care Medicine*, Vol. 161, July 1999.
3. Friedman, Lloyd N. *Tuberculosis: Current Concepts and Treatment*. Boca Raton: CRC Press. 1994.
4. Reichman, Lee B., and Hershfield, Earl S.,ed.: *Tuberculosis*: *A Comprehensive International Approach*, Second Edition. New York: Marcel Dekker, Inc. 2000.



Wonderful Wide Web Sites

ISDH Data Reports Available

The ISDH Epidemiology Resource Center has the following data reports and the Indiana Epidemiology Newsletter available on the ISDH Web Page:

http://www.statehealth.IN.gov (under Data and Statistics)

Indiana Cancer Incidence Report (1990, 95, 96)

Indiana Cancer Mortality Report (1990-94, 1992-96)

Indiana Health Behavior Risk Factors (1995-96, 97, 98,99)

Indiana Hospital Consumer Guide (1996)

Indiana Marriage Report (1995, 96, 97)

Indiana Mortality Report (97,98,99)

Indiana Natality Report (1995, 96, 97)

Indiana Natality/Induced Termination of Pregnancy/Marriage Report (1998)

Indiana Report of Diseases of Public Health Interest (1997, 98, 99)

Other web sites of interest:

www.in.gov/isdh/publications/prophylaxis/mpmain.htm

The following site allows access to the web page for any state health department in the United States:

http://www.polsci.wvu.edu/grad/klase/STATEHEALTH/sthlth.html

HIV Disease Summary

Information as of September 30, 2001 (based on population of 5,840,528)

HIV - without AIDS to date:

388	New cases from October 2000 thru September 2001	12-month incidence	6.64 cases/100,000
3,399	Total HIV-positive, without AIDS on September 30, 2001[1]	Point prevalence	58.20 cases/100,000[1]

AIDS cases to date:

373	New AIDS cases October 2000 thru September 2001	12-month incidence	6.39 cases/100,000
2,810	Total AIDS cases on September 30, 2001[1]	Point prevalence	48.12 cases/100,000[1]
6,299	Total AIDS cases, cumulative (alive and dead)		

[1]Counting only cases alive in September 2001

REPORTED CASES of selected notifiable diseases

Disease	Cases Reported in August *MMWR* Weeks 31-35		Cumulative Cases Reported January - August *MMWR* Weeks 1-35	
	2000	2001	2000	2001
Campylobacteriosis	125	98	384	299
Chlamydia	1,539	1,357	9,146	9,929
E. coli O157:H7	36	16	82	55
Hepatitis A	21	12	51	65
Hepatitis B	4	9	36	35
Invasive Drug Resistant *S. pneumoniae* (DRSP)	9	7	150	140
Gonorrhea	778	638	4,218	4,142
Legionellosis	4	3	26	15
Lyme Disease	8	8	19	17
Measles	0	0	0	4
Meningococcal, invasive	0	3	27	29
Pertussis	24	19	62	46
Rocky Mountain Spotted Fever	1	0	2	2
Salmonellosis	119	96	410	364
Shigellosis	243	25	1,133	157
Syphilis (Primary and Secondary)	28	17	255	119
Tuberculosis	9	15	85	70
Animal Rabies	0	0	0	1 (Bat)

For information on reporting of communicable diseases in Indiana, call the *ISDH Communicable Disease Division* at (317) 233-7665.

Indiana
Epidemiology
Newsletter

The *Indiana Epidemiology Newsletter* is published by the Indiana State Department of Health to provide epidemiologic information to Indiana health professionals and to the public health community.